Supreme Court, U.S.
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No. 00-1220

In The

Supreme Court of the United States

NEVADACARE, INC.,

Petitioner,

v.

RUBY SIMKINS and M & K ENTERPRISES,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

RESPONDENTS' BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

Whether the Ninth Circuit correctly found that the district court erred in not interpreting the ERISA Plan's ambiguous terms from the perspective of a lay person of average intelligence and experience; and that a lay person of average intelligence and experience would interpret the ambiguous terms of the ERISA Plan to include coverage for HDC/PSCR.

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RESPONDENTS' BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

Respondents, RUBY SIMKINS ("Ruby") and M & K ENTERPRISES ("M & K") respectfully request that the Court deny the Petition for Writ of Certiorari filed by Petitioner, NEVADACARE, INC. ("NevadaCare") as it fails to present a question worthy of review by the United States Supreme Court.

STATEMENT OF THE CASE

A. Factual Background

Respondent, RUBY SIMKINS ("Ruby") was diagnosed with Stage I breast cancer in October 1996. Ruby's physician removed the growth and advised Ruby to receive treatment and continued monitoring. Subsequently, Ruby's oncologist recommended that she undergo systematic radiation therapy. Ruby began systematic radiation therapy in December 1996 and received a total of thirty-three (33) radiation sessions. Ruby completed her radiation therapy in January 1997. The therapy was successful in resolving the detected nodules in her system.

Following her systematic radiation therapy, Ruby's physicians continued to monitor her recovery and progress by taking blood tests every three (3) months. Ruby's tests continued to show no sign of a relapse. Cautiously, her physicians advised Ruby that she would not be considered "cured" and would continue to be monitored for five (5) years from the date of her radiation therapy.

In the latter months of 1997, Ruby was aware that her employer, M & K ENTERPRISES ("M & K"), was in the process of changing health care providers. Due to her diagnosis and the ever-present possibility of relapse, Ruby was vigilant in making sure that any "new" health care provider would not limit her necessary treatment for breast cancer, should a relapse occur, or limit her need for constant monitoring.

Many persons took steps to insure coverage for Ruby. Ruby periodically called the Personnel Manager for M & K to make sure she would continue to be covered. In turn, the Personnel Manager discussed coverage with the insurance agent who recommended NevadaCare, to confirm that Ruby's and other employees' health problems would be covered. Additionally, before committing to a "new" health care carrier, Louis Simkins, president of M & K, made sure that coverage would continue for Ruby, should she suffer a relapse.

Satisfied that Ruby and other employees would be covered, M & K had an open enrollment on January 1, 1998, for its employees with their new health care carrier, NevadaCare. Ruby enrolled as a participant and/or beneficiary to NevadaCare's plan.

NevadaCare provided each new subscriber and enrolled dependent an Evidence of Coverage ("EOC") booklet describing the covered benefits. App. 52-109. The EOC booklet began with a Table of Contents which the beneficiary could turn to when attempting to determine coverage. App. 53-54. Of importance, the Table of Contents has separate sections indicated for "Services and

Benefits" (Part IV) and "Exclusions, Limitations and Non-Covered Services" (Part VI). *Id.*

In the latter part of January 1998, Ruby felt dizzy and weak and consulted her family physician. Upon submitting for an x-ray and subsequent CAT scan, Ruby was discovered to have at least twelve (12) nodules in her lungs and a plumb size mass on her liver. Ruby was immediately diagnosed with Stage IV breast cancer by her oncologist.

Due to the advanced stage of her cancer, Ruby's treating physicians referred her to the U.C.L.A. Medical Center. At U.C.L.A., Ruby was seen by John Glaspy, M.D., Medical Director of the Bowyer-Surgery Oncology Center. Dr. Glaspy recommended that Ruby undergo state-of-the-art treatment of high dose chemotherapy with peripheral stem cell rescue (HDC/PSCR). Ruby Simkins initiated her treatment by undergoing five (5) chemotherapy sessions in Las Vegas, at the direction of Dr. Glaspy, but under the supervision of her local oncologist.

U.C.L.A. Medical Center requested coverage from petitioner, NevadaCare for the HDC/PSCR procedure via letter dated April 3, 1998. *Respondents' Appendix* 1. In the April 3, 1998 letter, U.C.L.A. specifically outlined that Ruby Simkins needed the high dose chemotherapy procedure, with peripheral stem cell rescue support, and might also need a separate bone marrow support procedure. *Id.* Although the letter requesting approval of the procedure was nothing more than a form letter used by Dr. Glaspy to quickly secure approval for his patients, it is clear that the two procedures, HDC/PSCR and HDC

with bone marrow transplant, were outlined and contemplated to be two distinct and separate procedures. *Id.*

NevadaCare denied coverage, in a letter dated April 30, 1998, simply stating that "[t]he requested services for autologous bone marrow transplant for Ruby Simkins has been reviewed and denied as a noncovered benefit" because "tissue transplant coverage" was limited to allogenic bone marrow transplants. *Res. App.* 2.

Ruby Simkins was forced to frantically secure the funds to undergo the necessary and potentially life-saving peripheral stem cell rescue procedure after NevadaCare unreasonably denied coverage for the same. Ruby was admitted to the U.C.L.A. Medical Center on June 22, 1998 to begin her treatment. On July 3, 1998, Ruby received her peripheral stem cell transfusion. Immediately following her HDC/PSCR procedure, Ruby remained at U.C.L.A. being closely monitored by Dr. Glaspy, and his staff, to ensure positive recovery.

B. High Dose Chemotherapy with Peripheral Stem Cell Rescue

High dose chemotherapy with peripheral stem cell rescue (for the convenience of the Court, hereinafter referred to as "HDC/PSCR") is a widely recognized and state-of-the-art medical procedure used to treat patients with breast cancer. HDC/PSCR is a multi-stage medical procedure designed to treat breast cancer patients with the highest possible success rate.

The first step of the HDC/PSCR procedure involves the patient being injected with a myeloid growth factor

designed to stimulate and multiply the rate of production of stem cells in her blood stream. The physician then extracts the cancer patient's white blood cells from her blood stream, to "harvest" the necessary number of stem cells for transfusion. The harvesting procedure is done by extracting blood from the patient. From this blood, the stem cells are collected. The harvesting is normally a three (3) to four (4) day procedure. Once the requisite number of stem cells have been "harvested" they are frozen and stored until after the high dose chemotherapy is administered.

Next, the patient undergoes a high dose cycle of chemotherapy. There is a direct correlation between the level of chemotherapy and radiation administered to a patient and the amount of cancer destroyed. Thus, high dosages of chemotherapy will be more successful at destroying more cancer cells than lower dosages. These high dosages of chemotherapy, which can be up to several hundred times the normal dosages, not only eradicate cancer cells, but also destroy a considerable portion of the patient's other normal living cells. A patient who is able to withstand higher levels of chemotherapy will have a greater likelihood of effectively controlling or combating her cancer.

Normally, the high level of chemotherapy would prove fatal to the patient. This is because a patient who receives high dose chemotherapy treatment is very susceptible to opportunistic infections due to the eradicating effects of the therapy. In order to "rescue" the patient after the high dose chemotherapy is complete, the patient's own previously harvested and stored stem cells are reinfused into her system. This helps restore immune

functions, thereby minimizing the toxic effects of the high dose chemotherapy and avoiding the otherwise lethal effects of the treatment.

As with any other transfusion procedure, the danger of rejection exists when reinfusing the stem cells back into the body. However, since HDC/PSCR involves the patient's own organic material being reinfused, the danger of rejection is virtually nonexistent.

The final stage often varies in length of time. The patient must be monitored to insure that she does not develop fever or infection. Any such condition or infection could be fatal to the patient. The patient is also monitored to insure that the growth and multiplication of the stem cells is adequate to allow survival of the patient.

For breast cancer patients who are treated with HDC/PSCR, complete responses are achieved in a majority of patients. At a median duration of follow-up examination of two (2) years, approximately 20% remain disease free. Without HDC/PSCR, breast cancer patients like Ruby Simkins, are almost certain to die within weeks.

C. Procedural Background

Respondents filed their complaint on August 7, 1998, with the United States District Court for the District of Nevada. Respondents sought not only to recover costs of the HDC/PSCR procedure, but also injunctive relief preventing petitioner from denying coverage for the procedure.

The district court heard oral arguments on cross motions for summary judgment on June 22, 1999. On July

20, 1999, the district court issued its Order granting summary judgment in favor of petitioner.

Respondents appealed the decision to the United States Court of Appeals for the Ninth Circuit. Oral arguments were heard before the Ninth Circuit panel on June 14, 2000. The Ninth Circuit issued its written opinion on October 3, 2000, and issued an amended opinion on October 31, 2000.

The Ninth Circuit panel reversed the district court's decision, and ordered that summary judgment be entered in favor of Respondents, Ruby Simkins and M & K Enterprises.

MISSTATEMENT OF FACT

Petitioner inaccurately implies that Ruby sought out Dr. John Glaspy at U.C.L.A. for treatment for her breast cancer via a bone marrow supported procedure. *Petition for Certiorari*, 5. More accurately, Dr. Glaspy requested authorization for "high dose chemotherapy with autologous peripheral blood stem cell". *Res. App. 1.* The written request did include the possibility of additional treatment via bone marrow support, should the physicians be unable to collect a sufficient number of stem cells from Ruby's blood. *Id.* Luckily, Ruby's doctors were able to harvest enough stem cells from her blood and the bone marrow support was never needed.

REASONS FOR DENYING THE WRIT

A. Standard considered for granting petition for writ of certiorari not met by petitioner

A Petition for Certiorari is not a matter of right for any party, but rather a matter of judicial discretion. *Rules of the Supreme Court of the Untied States,* Rule 10. Rule 10 outlines the considerations the Court will take into account when considering a petition for writ of certiorari. Specifically, Rule 10 provides,

> "Rule 10. Considerations Governing Review on Certiorari
>
> Review on a writ of certiorari is not a matter of right, but of judicial discretion. ***A petition for a writ of certiorari will be granted only for compelling reasons.*** The following, although neither controlling nor fully measuring the Court's discretion, indicate the character of the reasons the Court considers:
>
> (a) a United States court of appeals has entered a decision in conflict with the decision of another United States court of appeals on the same important matter; has decided an important federal question in a way that conflicts with a decision by a state court of last resort; or has so far departed from the accepted and usual course of judicial proceedings, or sanctioned such a departure by a lower court, as to call for an exercise of this Court's supervisory power;
>
> (b) a state court of last resort has decided an important federal question in a way that conflicts with the decision of another state

> court of last resort or of a United States court of appeals;
>
> (c) a state court or a United States court of appeals has decided an important question of federal law that has not been, but should be, settled by this Court, or has decided an important federal question in a way that conflicts with relevant decisions of this Court." (Emphasis added).

In this case, no compelling reason exists which requires the granting of certiorari. The issuance of an opinion by the Ninth Circuit's panel contrary to petitioner's position, does not constitute a "far reaching" departure or "compelling reason" sufficient enough to warrant granting of the writ for certiorari.

The Ninth Circuit's decision is not one directly "in conflict with the decision of another United States court of appeals on the same ***important*** matter" as outlined in Rule 10(a). Likewise, Ninth Circuit decision in *Simkins* is not "so far departed from the accepted and usual course of judicial proceedings, or sanctioned such a departure by a lower court, as to call for an exercise of this Court's supervisory power".

As outlined below, the instant petition for certiorari does not warrant the Supreme Court's valuable time and judicial resources.

B. Ninth Circuit correctly held that the terms used by petitioner were ambiguous and that a lay person of average intelligence and experience would interpret the terms to provide coverage for the requested HDC/PSCR

ERISA was enacted "to promote the interests of employees and their beneficiaries in employee benefit plans" *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90, 103 S. Ct. 2890, 2896, 77 L. Ed. 2d 490 (1983), and "to protect contractually defined benefits," *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 148, 105 S. Ct. 3085, 3093, 87 L. Ed. 2d 96 (1985), as quoted in *Firestone Tire and Rubber Co. v. Burch*, 489 U.S. 101, 113, 109 S. Ct. 948, 956, 103 L. Ed. 2d 80 (1989). Generally, courts have held that benefit plans are to be read broadly and in a manner that avoids forfeiture of benefits. *Helms v. Monsanto*, 728 F.2d 1416, 1420 (11th Cir. 1984). The Ninth Circuit simply followed the intent of ERISA, and correctly interpreted the plan based on the specific terms used for the vantage point of a lay beneficiary with average intelligence and experience.

1. The Ninth Circuit did not hold that all general medical terms were ambiguous per se

Petitioner attempts to blur the issue by arguing that the *Simkins* decision stands for the overly broad proposition that ***all*** medical terms are ambiguous per se. *Pet.* 10-11. That is not what the Ninth Circuit decision held.

ERISA requires the summary plan description to "be ***written in a manner calculated to be understood by the average plan participant***, and shall be sufficiently accurate and comprehensive to reasonably appraise such

participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022(a) (Emphasis added). The Ninth Circuit decision in *Simkins* simply reinforced this requirement.

> The Ninth Circuit's decision outlined that
>
> ***[w]e believe the average person would not understand the term "tissue transplant" to encompass HDC/PSCR, because she would not understand stem cells to be "tissue."*** Instead, the average person would focus on the fact that stem cells in this procedure are a component of the patient's blood . . . ***The average person is not likely to understand blood to be tissue,*** especially when the Plan specifically discusses blood transfusions separately from tissue transplants and places tissue transplant coverage within the organ transplant section, a locational choice that has a distinct potential of misleading and confusing average plan participants. ***Because the stem cells would not be understood to be tissue, the average person would have no reason to believe the tissue transplant exclusion extended to HDC/PSCR.***

App. 12-13. (Emphasis added).

As is easily evidenced by the opinion, by no means did the Ninth Circuit hold that *all* general medical descriptions are ambiguous per se. There is no issue of great uncertainty that needs to be resolved by the Supreme Court as to what medical terms are ambiguous and which are not. Clearly, in accordance with both the *Simkins* decision, and the relevant provisions of the ERISA statute itself (29 U.S.C. § 1022), only vague medical terms that are not clearly understood by a beneficiary of "average intelligence and experience" will be deemed

ambiguous. Those general medical terms used in ERISA plans that are clearly understood by lay beneficiaries will not be deemed ambiguous. This determination should be determined by the individual trial courts, on a case by case basis.

2. The Ninth Circuit's decision does not create a conflict in the operation of the HMO Act and ERISA

Petitioner suggests that the Ninth Circuit's decision in this case, requiring that the plan description to be clear and unambiguous, creates a potential conflict in the operation of two federal statutes, to wit: Health Maintenance Organization Act of 1973 ("HMO Act") and the Employee Retirement Income Security Act of 1974 ("ERISA"). *Pet.* 9-10. Specifically, petitioner argues that the decision "***diminishes*** the ability of HMO plans governed by ERISA to provide low cost medical insurance." *Id.* (Emphasis added). However, petitioner fails to outline specific examples as to how the *Simkins* decision puts ERISA and the HMO Act at odds.

Petitioner's argument is tenuous, hypothetical and unsupported. Courts have considered similar claims by parties that ERISA could hypothetically conflict with the HMO Act, and have failed to give such hypothetical arguments any credence. *See, Hewlett-Packard Company v. Barnes,* 571 F.2d 502, 504-505 (9th Cir. 1978) ("Appellant suggests that some HMOs may ***in the future*** "transform" into employee benefit plans to avoid state regulation, but fails to point out any example of such "transformation," or, for that matter, any specific conflict between ERISA

and the HMO Act. We decline to upset ERISA's preemptive clause on such hypothetical grounds.") (Emphasis added).

Congress' intent to provide lower-cost health care to the public by passing the HMO Act, and ERISA's requirement that a plan description be "written in a manner calculated to be understood by the average participant" are fundamentally not in conflict. Rather, these statutes should be interpreted harmoniously, with each fostering the cost-effective health care for Americans everywhere. Courts must read statutes to give effect to each if this can be done while preserving their respective sense and purpose. *Morton v. Mancari*, 417 U.S. 535, 551, 94 S. Ct. 2474, 2483, 41 L. Ed. 2d 290 (1974).

The only thing the *Simkins* decision requires, is that the plan be drafted clearly, from the perspective of a lay person of average intelligence and experience so that the same lay person would be able to discern what procedures were covered and what procedures were excluded from coverage. This is identically what is required from the statute itself. The *Simkins* decision creates no more tension between the statutes. Accordingly, petitioner's argument deserves to be given no weight.

3. Simple definitions could have clearly put Ruby on notice that the HDC/PSCR procedure would not be covered, without much cost to petitioner

Petitioner argues that the Ninth Circuit decision in this case would require them to draft plans "choked with detail and hopelessly confusing" descriptions of over

94,000 procedures. *Pet.* 14-15. This argument is a gross exaggeration of the requirements required by statute.

As outlined above, ERISA requires plans to be drafted ***"in a manner calculated to be understood by the average plan participant . . . "*** 29 U.S.C. § 1022(a). Assuming this policy was intended generally to provide coverage for medical care and not exclude coverage for 94,000 procedures, the focus is on the clarity of which procedures they intend to communicate to the insureds were excluded. In this case, petitioner could have done an array of things to comply with these requirements.

For instance, petitioner could have included select definitions which would assist in clearly describing coverage to their beneficiaries without the fear of "choking" their policies with a list of 94,000 specific procedures. Logic dictates, and courts have followed, that when determining coverage under ERISA plans, one of the starting points is to review the definition section of the plan. *See, Schachner v. Blue Cross and Blue Shield of Ohio*, 77 F.3d 889 (6th Cir. 1996) (in determining coverage for employee's cardiac rehabilitation therapy, the court turned to the definition for "Treatment by Physical Means" to determine the existence of any ambiguity. The Sixth Circuit determined the phrase unambiguous relying on the definition included in the certificate.). The Ninth Circuit similarly took into consideration the definition section of the plan at issue in reaching its decision.

The Ninth Circuit reconciled the lay beneficiaries interpretation of "covered benefits" by considering, *inter alia*, the list of definitions outlined in the plan.

Petitioner could have accomplished the clarity required by the Ninth Circuit's decision by simply including a descriptive definition for "blood transfusion." Such a definition could concisely outline that transfusions which are performed to accomplish the re-infusion of "tissue," such as stem cells, would not be covered as a blood transfusion. Or petitioner could have included a definition/provision that transfusions, coupled with other procedures, such as high dose chemotherapy, would likewise not be covered under the plan. These or other simple definitions were never included in the plan. App. at 54-66.

In fact, petitioner's plan not only does not define "blood transfusion", but also does not define "blood." *Id.* A simple definition for blood could have outlined those components, like stem cells, whose re-infusion would not be covered under the covered benefit "blood . . . and [its] administration." App. 75. Further, the definition for blood could have specified that "blood components," such as stem cells, would be considered "tissue" for purposes of determining coverage. The plan contained no such definition/provision.

As the Ninth Circuit also pointed out, "[a]n average person would also reasonably conclude that the general term chemotherapy covers all levels of chemotherapy used in treatment."[1] The plan also did not include a

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[1] Petitioner finds fault with the Ninth Circuit's analysis in looking at the separate provision providing coverage for "chemotherapy" when determining the reasonable interpretation by a lay beneficiary. *Pet.* 17 note 5. Petitioner contends that the Ninth Circuit's determination that the

definition for "chemotherapy" or "high dose chemotherapy," or any provision outlining which "chemotherapy" procedures would be covered and which would not. App. 54-66.

As the Ninth Circuit outlined, courts have long held that "insurers should be expected to set forth any limitations on its liability clearly enough for a common lay person to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence." *Kunin v. Benefit Trust Life Insurance Co.*, 910 F.2d 534, 540 (9th Cir. 1990). Courts have held that ERISA's summary plan description requirements were intended to arm employees with enough information to enable them to enforce their rights under the plan. *See, Sanatana v. Deluxe Corp.*, 12 F. Supp. 2d 162 (D. Mass 1998). In this case, petitioner chose not to include any such simple definitions as part of its plan, preferring to vaguely address broad areas of coverage and exclusions. This Court should not reward petitioner for its poorly drafted, misleading and vague policy by granting certiorari.

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provision providing coverage for "chemotherapy" could be interpreted to include coverage for all chemotherapy is somehow flawed. Petitioner argues that "[i]t is medically unadvisable, if not impossible, to receive HDC as a stand-alone procedure." *Id.* Petitioner's criticism then begs the question: if it is medically unadvisable, if not impossible, to receive HDC as a stand-alone procedure, why does the plan, drafted by petitioner, provide coverage for "chemotherapy" without reference to any other supportive procedure? App. at 75. Petitioner is responsible for the reasonable interpretation it now chastises the Ninth Circuit for making. It should not be allowed to benefit from its own ambiguities.

4. Ninth Circuit did not sanction the billing practice of "unbundling" in determining coverage in ERISA plans

Petitioner argues that the Ninth Circuit decision sanctions providers and insureds to engage in the billing practice of "unbundling" when dealing with ERISA plans. *Pet.* 16-17. Petitioner wants the Supreme Court to believe that the Ninth Circuit condones the billing practice, and relied solely on "unbundling" in reaching its decision. *Pet.* 16-19. Again, this is simply inaccurate.

As petitioner points out, "unbundling" is a billing practice that occurs when a provider bills for both a "major" and "minor" procedure on the same day of service in an effort to receive payment for components which might not be covered collectively, or to receive higher payments by billing them separately. *Pet.* 17. The Ninth Circuit did not address the billing practice of "unbundling," instead focusing on a reasonable beneficiary's consideration in "trying to assess whether an insurance plan covered a complex procedure." App. 29, note 6. The Ninth Circuit determined that such considerations would reasonably include whether the plan covered the component subparts of the complex procedure.

The Ninth Circuit recognized *Hendricks v. Central Reserve Life Insurance Co.*, 39 F.3d 507 (4th Cir. 1994), which denied consideration of the fragmenting of the procedure when denial of coverage was based on the "experimental" exclusion. However, as the Ninth Circuit correctly held, *Hendricks* is distinguishable from the instant case, where the procedure was denied not under

an "experimental" exclusion, but under a "tissue transplant" exclusion. App. 14. The Ninth Circuit distinguished the cases, by correctly determining that in cases where the Court is asked to determine the ambiguity of terms used in a plan, "[a]n average person trying to assess whether an insurance plan covered a complex procedure reasonably would look to whether the component parts are covered . . . " *Id.*

C. The Ninth Circuit did not rely on *contra proferentem* in reaching its decision that the district court erred in granting summary judgment for petitioner

Petitioner raises the specter of the *contra proferentem* rule by citing an array of cases to illustrate that different courts have applied the doctrine of *contra proferentem* in the ERISA context, while others have not. *Pet.* 19-23. Petitioner hopes that this canvassing exercise is sufficient to warrant granting of its petition for writ of certiorari in the instant case.[2] It is not.

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[2] It should also be pointed out that in the cases cited by petitioner, where the *contra proferentem* rule was accepted or rejected in the ERISA benefits context, the parties have either deemed it unworthy to petition the Supreme Court for writ of certiorari to review the split in Circuits or the Supreme Court has itself refused to grant certiorari to review the same. *Pet.* 22-23. Similarly, the Supreme Court should refuse to grant certiorari in this case. The application of a doctrine construing ambiguous policy language against the insurer is not an important matter for the highest court in the country to review. This is particularly true, when the Circuit Court applied a different statutory rule of construction in rendering its ruling, to wit: 29 U.S.C. § 1022(a).

Although petitioner goes to great lengths to outline the split among circuits concerning the use of *contra proferentem* rule, it fails to point out to this Court that the Ninth Circuit never relied on the rule in reaching its decision that the district court erred in granting summary judgment in favor of petitioner. App. 1-16. In actuality, the Ninth Circuit reached its decision by summarizing that ***"[b]ecause the Plan can reasonably be read to cover HDC/PSCR***, the district court improperly granted summary judgment to NevadaCare."[3] App. 15 (Emphasis added).

The Ninth Circuit relied exclusively in its decision by applying the standard already required by ERISA. That is, that the summary plan description "shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022. As its starting point, the Ninth Circuit analyzed the actual language and terms used by petitioner in its plan, and "considered whether a person of average intelligence and experience would construe the term 'tissue transplant' to encompass HDC/PSCR." App. 12. The Ninth Circuit determined such an average person would not understand the ambiguous term to

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[3] The Ninth Circuit did go on to apply the *contra proferentem* rule in entering summary judgment in favor of Simkins by holding that "the existence of such a reasonable interpretation means that, even if contrary reasonable interpretations exist, a jury would be required to adopt the one that favors coverage for the insured . . . the district court should have granted Simkins' motion for partial summary judgment." App. 15.

exclude HDC/PSCR because such a person "would not understand stem cells to be 'tissue.' " App. 12-13.

In fact, the petitioner itself never argued that the split in circuits regarding *contra proferentem* was an issue that the Ninth Circuit needed to address. Res. App. 5-27. Only now does the petitioner raise the split between the circuits in a desperate attempt to secure review by this Court. As outlined above, the *contra proferentem* rule was not applied by the Ninth Circuit in reaching its decision regarding the wisdom of the district court's granting of petitioner's motion for summary judgment. However, it appears that petitioner would essentially request the Supreme Court to apply a reverse *contra proferentem* rule that would construe poorly drafted, unclear language against the insured. Therefore, Court should not grant the petition for writ of certiorari simply to resolve an academic exercise desperately presented by petitioner at the eleventh hour.

D. Petitions for writ of certiorari have been consistently denied in similar ERISA cases

The United States Supreme Court has repeatedly denied certiorari in similar cases where the Ninth Circuit Courts of Appeals has determined the ambiguity/non-ambiguity of specific policy provisions within an ERISA plan. *See, Kunin v. Benefit Trust Life Insurance Co.*, 910 F.2d 534 (9th Cir. 1990) (ERISA plan's term "mental illness" in policy limitation held ambiguous), *cert. denied*, 498 U.S. 1013 (1990), *rehearing denied*, 498 U.S. 1074 (1991); *Peterson v. American Life & Health Insurance Co.*, 48 F.3d 404 (9th Cir. 1995) (ERISA policy exclusion for coronary bypass

surgery held unambiguous), *cert. denied*, 516 U.S. 942 (1995); *Aul v. Allstate Life Insurance Co.*, 953 F.2d 1386 (9th Cir. 1992) (ERISA policy unambiguously precludes vesting of benefits), *cert. denied*, 506 U.S. 1021 (1992); *Marsh By and Through Marsh v. Allstate Life Insurance Co. of New York*, 953 F.2d 1387 (9th Cir. 1993) (ERISA termination provision does not conflict with other provisions and is therefore not ambiguous), *cert. denied*, 510 U.S. 826 (1993).

The denial of certiorari is not limited to those cases involving the Ninth Circuit. The United States Supreme Court has also consistently denied certiorari to cases determining the ambiguity/non-ambiguity of specific policy provisions within an ERISA policy from other courts. *See, Brewer v. Lincoln National Life Insurance Co.*, 921 F.2d 150 (8th Cir. 1990), *cert. denied*, 501 U.S. 1238 (1991); *Schachner v. Blue Cross and Blue Shield of Ohio*, 77 F.3d 889 (6th Cir. 1996), *cert. denied*, 519 U.S. 865 (1996).

CONCLUSION

Petitioner argues that the instant case involves "[i]mportant and substantial questions" arising from the Ninth Circuit opinion. In reality, although breast cancer treatment and insurance coverage for breast cancer treatment is of vital concern in our country, this case involves a very narrow decision by the Ninth Circuit as to the specific language included in NevadaCare's unique policy provision, and the applicability of that language to the requested HDC/PSCR procedure requested by Ruby Simkins. There is no demonstration that the resolution of the language at issue has some far reaching effect beyond

this case. The Ninth Circuit opinion is written narrowly so as to apply almost exclusively to the instant action. There will be no far reaching effect resulting from the panel's decision which might warrant the granting of certiorari.

The petition for writ of certiorari should be denied in all respects.

Respectfully submitted this 1st day of March, 2001.

LELAND EUGENE BACKUS, ESQ.
Counsel of Record
EDGAR CARRANZA, ESQ.
BACKUS & ASSOCIATES, LTD.
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Counsel for Respondents
Ruby Simkins and
M & K Enterprises

USLA Medical Center

[Address Omitted In Printing]

April 03, 1998

Nevadacare
Att: Case Management

Re: Ruby Simpkins*

Crt: 152320950 01

Group: 130047

Sub: Louis Simpkins

Pending #'s: Dr. Glaspy P71460 / Facility P71461

To Whom It May Concern,

Ms. Simpkins is a 54 year old female referred to UCLA Medical Center for high dose chemotherapy with autogolous peripheral blood stem cell +/- bone marrow support. Ms. Simpkins has a diagnosis of Breast Cancer.

I am requesting *written medical necessity authorization* for the above procedure. We cannot begin treatment without prior authorization. The procedure will include Catheter Placement, Pheresis (both conducted as outpatient procedures) and then Admit for High Dose Chemotherapy and Stem Cell Transplant.

Your attention to this matter is appreciated. If you have any medical questions, please contact Sara Rasti, R.N., at (310) 206-3806.

Please reply with a decision regarding this case as soon as possible by FAX (310) 206-5469 or phone (310) 206-7920.

---

* Correct spelling should be Simkins.

Sincerely,

/s/ Ellen M. Steingrebe
Ellen M. Steingrebe
Bone Marrow Transplant Insurance Coordinator
UCLA School of Medicine
10945 Le Conte Ave., Suite 2120
Box 957049
Los Angeles, CA 90095-7049

Res. App. 3

NevadaCare

M & K Enterprises
Louis Simkins
3748 Scripps Way
Las Vegas, NV 89103

April 30, 1998

Plan: NevadaCare POS 3E-97

Employer Group: 130047

Dear Mr. Simkins,

This letter is to inform you of the following: The requested services for a autologous bone marrow transplant for Ruby Simkins has been reviewed and denied as a noncovered benefit. The NevadaCare evidence of coverage (EOC), which you received at the time of enrollment outlines the benefits of transplant services and specifically states that tissue transplant coverage is limited to allogenic bone morrow only. This denial of benefits is a denial of plan coverage and is not related to the medical necessity, per the diagnosis.

If you have any questions or need additional information, please do not hesitate to contact NevadaCare at (702) 474-7241.

Sincerely,

/s/ Baltazar A. Lozano, Jr
Baltazar A. Lozano, Jr.
Director of Claims and Client Services

CC: Keith Beagle, President
Eddie Burkhart, Director of Sales and Marketing
John Thielen, Sales Representative
Carl Ross, RN, UR/QA Manager
Jean Patrick, RN, Utilization Review
Claims/Client Services Staff

No. 99-16844

IN THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

RUBY SIMKINS and
M & K ENTERPRISES,

Plaintiffs-Appellants,

v.

NEVADACARE, INC., a Nevada corporation,
JOHN DOES I through X and
DOE CORPORATIONS I through X,

Defendants-Appellees.

APPEAL FROM THE UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

BRIEF FOR THE APPELLEE NEVADACARE, INC.

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* * *

STATEMENT OF SUBJECT MATTER AND APPELLATE JURISDICTION

The Appellee, NevadaCare, Inc., has no objection to the statement of subject matter and appellate jurisdiction as set forth in the appellant's Brief.

ISSUES PRESENTED FOR REVIEW

1. Whether the District Court erred in granting NevadaCare, Inc.'s Counter-Motion for

Summary Judgment, holding that the plain unambiguous language of the pertinent provision of the Plan, Paragraph R, which provides that "[t]issue transplant coverage is limited to allogenic bone marrow only," did not require coverage of the HDC/PSCR procedure, which undisputedly is a tissue transplant, but not an allogenic bone marrow transplant.

2. Whether the District Court erred in denying Simkins' Motion for Summary Judgment requesting coverage for a procedure which is beyond the scope of benefits Simkins is entitled to receive under the Plan.

STANDARD OF REVIEW

The standard of review on appeal of a District Court's grant of summary judgment is "de novo." *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317 (9th Cir. 1995), *citing Jesinger v. Nevada Fed. Credit Union*, 24 F.3d 1127, 1130 (9th Cir. 1994). In reviewing the District Court's decision, this Court must "engage in the same exercise as the district court." *Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 380 (7th Cir. 1994). Where, as in the instant case, the parties do not contest the facts, the Appellate Court needs only to decide whether the District Court correctly applied the substantive law. *Associated Gen. Contractors v. Smith*, 74 F.3d 926, 929 (9th Cir. 1996).

In cases pertaining to claims based on the Employment Retirement Income Security Act 29 U.S.C. § 1001, *et. seq.* ("ERISA"), where the plan document endowed the fund with authority to interpret the terms of the plan, the Appellate Court "would be required to accept the fund's

reading of the plan document so long as it was not 'downright unreasonable.' " *Id. See also Killian v. Healthsource Provident Adm'rs, Inc.*, 152 F.3d 514, 520 (6th Cir. 1998), *Miller v. Metropolitan Life Ins. Co.*, 925 F.2d 979, 986 (6th Cir. 1991).

BRIEF STATEMENT OF THE CASE

This case arises out of the denial of ERISA plan benefits for the procedure known as high dose chemotherapy with peripheral stem cell rescue ("HDC/PSCR"). Appellant Louis Simkins, dba M&K Enterprises ("M&K") had contracted with NevadaCare, Inc. ("NevadaCare") for benefits as set forth in the NevadaCare Point of Service Evidence of Coverage ("EOC" or the "Plan"). *See* CR 13 at Exh. 8. Appellant Ruby Simkins ("Simkins") was a beneficiary under the Plan. Simkins and M&K originated the instant action challenging on numerous grounds the decision of NevadaCare to deny benefits for the HDC/PSCR based on the determination that the requested treatment was not an item covered under the plan. The District Court granted the Counter-Motion for Summary Judgment filed by NevadaCare, affirming the denial of coverage. Simkins appealed the holding of the District Court.

SUMMARY OF ARGUMENT

The District Court properly held, based on the pleadings and record before it, that NevadaCare's denial of benefits for Simkins' HDC/PSCR was proper under the clear terms of the Plan. The Plan provides that only certain services are covered, and HDC/PSCR is not listed

as a covered service. Simkins' original request for coverage was for a bone marrow tissue transplant. While there is coverage for tissue transplants under the plan, such coverage is expressly limited to "allogenic bone marrow transplants." *See* CR 13, Exh. 8 at p. 000026. As HDC/PSCR does not involve an allogenic bone marrow transplant, it is not covered under the tissue transplant provision. The Plan provisions in this regard are conspicuous and unambiguous, as the terms of the Plan are not susceptible to more than one reasonable interpretation, especially taken in the context of the entire document.

The District Court further properly held that because the Plan grants NevadaCare discretionary authority in coverage decisions, NevadaCare's denial of benefits to Simkins must be reviewed for "abuse of discretion." NevadaCare's refusal of payment for an uncovered bone marrow transplant was based on a reasonable reading of the Plan terms, and does not constitute abuse of discretion.

The argument that alternative grounds for coverage of HDC/PSCR could be found by fragmenting it into a blood transfusion and chemotherapy is not properly before this Court, as it is raised for the first time on appeal. Assuming *arguendo* that the blood transfusion argument may be considered, it nevertheless must fail as the law does not allow the insured to fragment the procedures in this way to obtain coverage. Furthermore, it is an undisputed medical fact that HDC/PSCR involves not a blood transfusion, but a tissue transplant, and any contrary view is erroneous and unreasonable.

For the above reasons, the District Court's holdings in this matter are correct, and must be affirmed.

ARGUMENT

A. The District Court did not err in its conclusion that "the plain unambiguous language of NevadaCare's EOC requires denial of coverage for Ms. Simkins HDC/PSCR."

The District Court correctly determined that no ambiguity exists in the Plan in connection with the denial of coverage for Simkins' HDC/PSCR. Plans governed by ERISA are interpreted in accordance with the federal law. *See Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 110, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989). A contract must be read as a whole, and every part interpreted in the context of the whole, with preference given to reasonable interpretations. Contract terms should be given their ordinary meanings, and when the terms of a contract are clear, the intent of the parties must be ascertained from the contract itself. *Klamath Water Users Protective Ass'n v. Patterson*, 191 F.3d 1115, 1119 (9th Cir. 1999). Straightforward language in an ERISA policy, as in any other contract, must be given its plain natural meaning. *Fischman v. Blue Cross & Blue Shield of Conn., Inc.*, 775 F. Supp. 513, 515 (D. Conn. 1991).

Ambiguity only exists in a contract when a term is one that is "susceptible of two or more distinct meanings . . . **Terms that are merely vague or indefinite are not construed against the drafter under the doctrine of *contra preferentem*.**" *Atwood*, 45 F.3d at 1324 (9th Cir.

1995) (Emphasis added). A court may not find an ambiguity based on "a strained instead of reasonable interpretation of . . . terms." *Tzung v. State Farm Fire and Casualty Co.*, 873 F.2d 1338, 1340 (9th Cir. 1989). An ambiguity may not be created "where the contract has a definite meaning, and where no reasonable basis exists for a difference of opinion about that meaning." *Brass v. Am. Film Techs., Inc.*, 987 F.2d 142, 149 (2d Cir. 1993).

Part IV of the Plan sets forth all of the "Services And Benefits Within the Managed Care Network." The first paragraph of this section provides:

> "You are eligible to receive the following medical car and services of doctors and other providers including medical, surgical, diagnostic, therapeutic and preventive services which are generally and customarily provided within the Managed Care Network."

See CR 13, Exh. 8 at 000021. An extensive list of covered services then follows. The only reasonable interpretation of this provision is that a Member is eligible for benefits under the Plan only in connection with the services listed in that Part. Such interpretation is also confirmed by reading the Plan as a whole, with a specific reference to the Part VI, § 29, which contains an exclusion for "[a]ny services or supplies not specifically listed in this Evidence of Coverage as covered benefits, services or supplies." See CR 13, Exh. 8 at 000030. HDC/PSCR is not listed in the Plan as a covered item.

Coverage for tissue transplants under the Plan, however, is limited under the following provision, adjudged unambiguous by the District Court:

R. Transplant Services

Coverage is provided for the Medically Necessary services required for **human tissue** and organ **transplants**, for the treatment of non-occupational disease or injury. All transplant related services must be pre-authorized by the NevadaCare Medical Director.

1. Organ transplants for heart, kidney, cornea, and liver. Liver transplant limited to that required as a result of biliary artresia only.

2. Tissue transplant coverage is limited to allogenic bone marrow only.

3. Coverage is provided for the necessary Hospital, surgical, laboratory, and x-ray expenses incurred by a donor for an authorized transplant to a Member, unless the donor has coverage for such expenses. (Emphasis added).

See CR 13, Exh. 8 at 000026. The exclusionary provision in the Plan further limits the tissue transplant coverage granted under the benefit provision. See CR 13, Exh. 8 at 000030. This provision is as follows:

31. We will cover services for covered organ transplant expenses, as defined below, incurred by a Member for an organ transplant approved by Us at a facility approved by Us, subject to those conditions and limitations described below. Transplant means pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation. We will cover only services, care and treatment received for or in connection with the approved transplantation of the following human organs:

1. Heart, Kidney, Cornea, and Liver. Liver transplant is limited to that required as a result of biliary atresia only.

2. Tissue transplant coverage is limited to allogenic bone marrow only.

For a transplant procedure to be considered approved, prior approval from the company's Medical Director is required in advance of the procedure.

Covered Expenses: For approved transplant procedures, and all related complications, We will cover only the following covered expenses:

1. Hospital expenses and physician's expenses will be covered under the same terms and conditions as We will cover care and treatment of any other covered injury or sickness, up to a maximum of $150,000 per transplant procedure.

2. Organ acquisition and donor cost. However, donor costs are not covered under the Group Plan if they are payable in whole or in part by any other Group Plan, insurance company, organization or person other than donor's family or estate. In addition, We will not cover acquisition and donor costs related to the removal of an organ from a Member for the purpose of transplantation into a recipient who is not our Member. (Emphasis added.)

There is also a catchall exclusion in the policy for "Any services or supplies not specifically listed in this Evidence of Coverage as covered benefits, services or supplies." See CR 13, Exh. 8, at 000030.

It is undisputed that HDC/PSCR is a tissue transplant. The only kind of tissue transplant covered under

the Plan is an allogenic bone marrow transplant. This policy provision is contained in both the benefit and exclusion provisions of the policy. It is undisputed that the HDC/PSCR procedure does not involve an *allogenic* bone marrow transplant. Rather, it involves an "autologous peripheral blood stem cell transplantation." Therefore, a reasonable beneficiary would not expect the above reference Plan provision to cover HDC/PSCR.[1] No ambiguity exists in this regard, as the provision of the Plan are not susceptible of two ore more distinct meanings and no other reasonable interpretation is possible. *Atwood*, 45 F.3d at 1324, *Klamath*, 191 F.3d at 1119, *Tzung*, 873 F.2d at 1340.

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[1] As Simkins' oncologist Dr. Glaspy noted in his Affidavit, *see* CR 9, a hypothetical average beneficiary could not be expected to know about the HDC/PSCR procedure, or what is involved in such a procedure, until it has been proposed or explained to such a person by a doctor in a manner similar to the explanation received by Simkins. It would be reasonable to expect a beneficiary to understand, after such an explanation, that HDC/PSCR does not involved an **allogenic** bone marrow transplant, but, to the contrary, involves re-transplantation of cells obtained from the patient's own body. Furthermore, following an explanation by a physician, it is reasonable to expect a patient to understand that "blood filtering to harvest stem cells," is not a mere blood transfusion, is involved in HDC/PSCR. See CR 9 at 000026.

B. Simkins' new contention that HDC/PSCR was covered under the blood transfusion and chemotherapy provisions of the Plan is waived because is it raised for the first time on appeal.

For the first time in the appellate brief, Simkins argues that HDC/PSCR should be covered because the NevadaCare Plan provides coverage for Chemotherapy and blood transfusions. While it is less than clear, Simkins appears to be arguing that coverage should be afforded under this theory because a reasonable person would believe that HDC/PSCR was covered under the chemotherapy and blood transfusion sections. This contention does not appear in the record. Further, Simkins herself did not appear to have had this "reasonable" belief at the time she prepared her Affidavit to Plaintiff's Motion for Summary Judgment and for a Permanent Injunction (See CR9, Affidavit of Ruby Simkins), which makes no mention of this latest interpretation of the Plan. Inexplicably, Simkins now also appears to argue that the procedure she underwent actually included a blood transfusion. Again, there is no evidence whatsoever supporting this statement.

To the contrary, the record below indicates that when Simkins' physicians requested coverage for the HDC/PSCR procedure, which she actually underwent, they referred to the procedure as a HDC/PSCR or high dose chemotherapy with autologous bone marrow transplant ("HDC/PSCR").[2] None of Simkins doctors ever

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[2] In an April 3, 1998 letter to NevadaCare, (*see* CR 9, Exh.1) Ms. Ellen M. Steingrebe, Bone Marrow Transplant Insurance Coordinator on behalf of the UCLA Medical Center, requested

suggested that the procedure they were recommending was a "simple blood transfusion" as Simkins now contends.

In her Motion for Permanent Injunction and Motion for Partial Summary Judgment, Simkins vigorously argued that HDC/PSCR is separate and distinct from an autologous bone marrow transplant and argued that *"Ruby Simkins is not requesting a bone marrow transplant."* (Emphasis added). See Motion for Permanent Injunction, CR 9, page 16. The District Court in this regard held that "[r]egardless of whether these are two different procedures, the **undisputed evidence** show they are both tissue transplants. Paragraph R states that the only tissue transplant that is covered under Ms. Simkins' plan is an allogenic tissue transplant." See Order, CR24, Page 13, (Emphasis added).

The District Court, based on the record before it, properly held that Simkins is not eligible for the requested benefits under the express terms of the Plan. The "blood transfusion" argument is improperly before this Court as well as flagrantly inconsistent with the record and legal precedent.

The "blood transfusion" argument has not been raised by Simkins in any pleading before the District

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"written medical necessity authorization" for " . . . high dose chemotherapy with autologous peripheral blood stem cell +/- bone marrow support . . . " Likewise, in the May 11, 1998 letter to Baltazar A. Lozano of NevadaCare, (*see* CR 13, Exh. 27) Dr. John Glaspy wrote: "As I am sure you are aware **autologous peripheral blood stem cell transplantation** is not an experimental technique, but rather a supportive technique . . . "

Court and is, therefore, waived on appeal.[3] Generally, Appellate Courts will not consider contentions raised for the first time on appeal. *Smith v. Marsh*, 194 F.3d 1045, 1052 (9th Cir. 1999). "Before an argument will be considered on appeal, 'the argument must be raised sufficiently for the trial court to rule on it.' " *Sofamor Danek Group, Inc. v. Brown*, 124 F.3d 1179, 1186 n.4 (9th Cir. 1997).

While there are exceptions to the rule that new issues may not be raised for the first time on appeal, none of the exceptions are applicable in this instance. *See Peterson v. Highland Music, Inc.*, 140 F.3d 1313, 1321 (9th Cir. 1998). The interests of justice dictate the exclusion of Simkins' new argument raised against NevadaCare at this late stage of the proceedings. There is no new legal issue or change in the law, justifying consideration of this new argument. Simkins failed to argue that any of the exceptions to the general rule apply, or mention any "exceptional circumstances" which prevented the issue from being raised in the District Court. **Thus, Simkins is now precluded from raising this issue.**

Furthermore, this Court should refuse to consider the contention that the HDC/PSCR is covered under the blood transfusion provision because Simkins has never made such an argument to the plan administrator. In *Taft v. Equitable Life Assurance Soc'y*, 9 F.3d 1469, 1472 (9th Cir. 1993), the court emphasized:

> **Nothing in the legislative history suggests that Congress intended that federal district courts**

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[3] *See also* Ninth Cir. Ct. Rule 28-2.5 ("As to each issue, appellant shall state where in the record on appeal the issue was raised and ruled on . . . ")

> **would function as substitute plan administrators**, a role they would inevitably assume if they received and considered evidence not presented to administrators concerning an employee's entitlement to benefits. Such a procedure would frustrate the goal of prompt resolution of claims by the fiduciary under the ERISA scheme. (Emphasis added).

For the reasons stated above, Simkins' contention that HDC/PSCR is covered under the blood transfusion provisions **should be disregarded by this Court**. *Id., see also Federal Deposit Insurance Corporation v. Castetter*, 184 F.3d 1040, 1046 n.5 (9th Cir. 1999), *Peterson*, 140 F.3d at 1321 (9th Cir. 1998).

C. Assuming arguendo that she had properly raised the blood transfusion issue below. Simkins should not be allowed to fragment the HDC/PSCR procedure into components in an attempt to obtain coverage.

Even if Simkins had properly asserted her blood transfusion argument before the District Court, Simkins this argument must fail as an impermissible fragmentation of the procedure to obtain coverage, impermissible under the law. In *Mattive v. Healthsource of Savannah, Inc.*, 893 F. Supp. 1559 (S.D. Ga. 1995), cited in the Simkins' appellate brief, the court held with respect to the coverage of HDC/PSCR procedure:

> **[t]he Court agrees with Defendant's argument that the Court should view the treatment as a whole and not fragment for the purposes of coverage. In this case, the Court agrees with**

> **the Fourth Circuit which has held that the fragmenting of the phases of treatment and the consideration of whether each fragment was covered under the terms of the contract produces "an unrealistic and distorted analysis."** *Hendricks v. Central Reserve Life Insurance Co.*, 39 F.3d 507, 514 (4th Cir. 1994). The court held that fragmenting in this was would (sic) allow partial coverage for almost any treatment "no matter how inconsistent with good medical practice." *Id.* at 515 (Emphasis added).

See also Hasty v. Central States, 859 F. Supp. 339 (N.D. Ind. 1994). The position taken by Simkins in her Appellate Brief is similarly unrealistic and distorted. In the District Court, all the parties, including Simkins and her counsel, treated HDC/PSCR as an integrated treatment, not susceptible to fragmentation into parts and not involving a blood transfusion.

Simkins' treating oncologist, Dr. Glaspy, stated in his Affidavit that "HDC/PSCR is a multi-step procedure," involving chemotherapy and cell harvesting. *See* CR9 at 000024. In his description of the procedure, (*see* CR9 at 000024-26) Dr. Glaspy never mentioned that a blood transfusion was in any way connected with the proposed treatment. Simkins never applied for coverage for a "blood transfusion" and did not undergo such a treatment. She received a stem cell transplant, described as such by her doctors, her counsel, and the courts. *See e.g. Wheeler v. Dynamic Eng'g, Inc.*, 62 F.3d 634 (4th Cir. 1995), extensively relied upon by Simkins:

> Stem cells are also located in the circulating, or peripheral, blood. In HDC/PSCR, the procedure

> at issue in this litigation, stem cells are harvested from a patient's bloodstream rather than from bone marrow. Prior to the administration of the HDC, blood is withdrawn from the patient and stem cells are separated from the blood by a process known as leukapheresis. Stem cells are then frozen and stored until after the administration of the HDC. After the HDC phase, **the stem cells are thawed and reinfused into the patient's bloodstream**. (Emphasis added).

The blood transfusion argument raised by Simkins has been unsuccessfully attempted in the case of *Bruening v. Constr. Workers Health Fund*, 165 F.3d 31, 1998 WL 691027 (7th Cir. (Wis.) 1998) (*Unpublished*).[4] The court, referring to the opinion of an independent medical review firm, Medical Review Institute of America, Inc. ("MRI"), stated:

> . . . although the stem cells are drawn from the blood in a PSCR, they are: (1) simply tissue suspended in the blood, rather than a functioning part of the blood; (2) returned to the patient by the same means as in an ABMT (catheterization followed by re-implantation in the marrow); and (3) "transplanted" in the same sense that marrow is in an ABMT. In this report, MRI explicitly concluded that the PSCR was a "tissue" transplant.

An interpretation of the HDC/PSCR provision as involving a blood transfusion is, therefore, erroneous, inconsistent with the undisputed medical facts, and

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[4] The unpublished decision is referred to herein for illustrative purposes only.

unreasonable. As such, it cannot give rise to coverage under the Plan.

D. The District Court correctly determined that NevadaCare's decision to deny coverage for Simkins' HDC/PSCR should be reviewed under the "abuse of discretion," not "de novo" standard[5]

The law in the Ninth Circuit pertaining to the standard of review of an ERISA administrator's decision is well-established. A denial of benefits challenged under 29 U.S.C. § 1132(a)(1)(B) is reviewed de novo 'unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan,' in which case an "abuse of discretion"[6] standard is applied. *Atwood*, 45 F.3d at 1321 (9th Cir. 1995), citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S.Ct. 948, 956-57, 103 L.Ed.2d 80 (1989).

The District Court determined that the following provisions of the subject Plan give NevadaCare discretionary authority:

> Medically Necessary – The use of services and/or supplies, as described in this Evidence of

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[5] The District Court emphasized that its holding in the instance case would not change if the applicable standard of review had been "de novo."

[6] Some of the Ninth Circuit cases state that an "arbitrary and capricious" standard is applied, while others use the term "abuse of discretion." The standards differ in name only. *Atwood*, 45 F.3d at 1321 N.1.

Coverage, which are required to identify or treat Your illness or injury and which are:

a. consistent with the symptoms or diagnosis and treatment of Your condition, disease, ailment or injury;

b. appropriate, safe, and effective with regard to standards of good medical practice;

c. not solely for Your convenience, Your Physician, Hospital or other health care provider;

d. consistent with the most appropriate supply of level of service which can be safely provided to You. When applied to an inpatient, it further means that Your medical symptoms or condition require that the diagnosis or treatment cannot be safely provided to You as an outpatient; and

e. consistent with medical policy and procedure as defined by the NevadaCare Quality Management Program. (*See* CR 13, Exh. 8 at 000015-16)

Prior/Pre-Authorization. That a Participating Provider or Physician must receive approval from an authorized staff member of NevadaCare, such as the Medical Director or his designee, before You can receive certain health care services. (*See* CR 13, Exh. 8 at 000016)

Complaint and Grievance Procedure.

. . .

NevadaCare will make a final decision for grievance about medical care services within fifteen (15) days of receiving written or oral

> **grievance**. A letter will be mailed to You stating NevadaCare's decision and the reason for the decision. The letter will tell You how You can appeal the decision if You are not satisfied. You must let NevadaCare know if You want to appeal the decision. (Emphasis added.) (*See* CR 13, Exh. 8 at 000038).

The District Court's determination is correct, as a plan must give discretionary authority to the administrator or fiduciary "in specific words" but *Firestone* does not require "magic words." *See e.g. Mattive*, 893 F. Supp. at 1565. The plan need only give the power to construe disputed terms or to resolve disputes over eligibility for benefits.*Id*. It has been held that a plan confers discretion when it "includes even one important discretionary element, and the power to apply that element is unambiguously retained by its administrator." *Bogue v. Ampex Corp.*, 976 F.2d 1319, 1325 (9th Cir. 1992).

Where the administrator is operating under a potential conflict of interests, a "heightened standard" is applied. The court in *Atwood* held that "this 'heightened standard' does not alter our traditional abuse of discretion review **in the absence of specific facts indicating that [administrator's] conflicting interest caused a serious breach of the plan administrator's fiduciary duty** to Atwood, the plan beneficiary." *Atwood*, 45 F.3d at 1322. (Emphasis added). The court held that it ultimately applies "a traditional abuse of discretion standard to the decisions of apparently conflicted employer- or insurer-fiduciaries unless the affected beneficiary comes forward

with further evidence indicating that the conflicting interest caused a breach of the administrator's fiduciary duty to the beneficiary" *Id.* at 1323.

It was held in this Circuit in *Lang v. Long-Term Disability Plan,* 125 F.3d 794 (9th Cir. 1997):

> . . . we must review the decisions of an apparently conflicted employer or insurer-fiduciary under the traditional abuse of discretion standard unless it appears that the conflict may have influenced the decision. To make such a showing, the **affected beneficiary must come forward with "material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self interest caused a breach of the administrator's fiduciary obligations to the beneficiary.**" *Citing Atwood* (citations omitted). (Emphasis added).

Simkins has not come forward in any pleading with material and probative evidence required to establish that an actual conflict of interests of NevadaCare has improperly influenced its decision in this matter. *See Atwood,* 45 F.3d at 1323, *see also Zavora v. Paul Revere Life Ins. Co.,* 145 F.3d 1118 (9th Cir. 1998). Thus, the District Court's ruling on the record before it that the "abuse of discretion" standard is appropriate for review of NevadaCare's denial of coverage was correct. This Court should therefore affirm the decision reached in the District Court.

E. The Court must uphold NevadaCare's interpretation of the terms of the Plan, unless such interpretation is "abuse of discretion."

Although this Court reviews *de novo* the District Court's grant of summary judgment, NevadaCare's decision should only be reversed if it constitutes abuse of discretion. *Siles v. Ilgwu National Retirement Fund*, 783 F.2d 923, 926 (9th Cir. 1985).

It is well-established in this Circuit that "ERISA plan administrators 'abuse their discretion if they render decisions without any explanation, or construe provisions of the plan in a way that conflicts with the plain language of the plan.' " *Taft*, 9 F.3d 1469, 1472, *quoting Eley v. Boeing Co.*, 945 F.2d 276, 279 (9th Cir. 1991), *Johnson v. Trustees of W. Conference of Teamsters Pension Trust Fund*, 879 F.2d 651, 654 (9th Cir. 1989). Furthermore, it is an abuse of administrator's discretion to rely on clearly erroneous findings of fact in making benefit determinations. *Id.* at 1473, *quoting Oster v. Barco of Cal. Employees' Retirement Plan*, 869 F.2d 1215, 1218 (9th Cir. 1988) (no abuse of discretion by an ERISA administrator unless the decision is "so patently arbitrary and unreasonable as to lack foundation in factual basis").

No abuse of discretion took place in the instant case. NevadaCare informed Simkins of the reasons for its decision in the original letter of denial of coverage, which stated that the requested treatment was not a covered benefit because of a policy limitation. The letter further stated that the denial was not related to medical necessity. *See* CR9 at Exh. 2. ("The NevadaCare evidence of

coverage (EOC), which you received at the time of enrollment outlines the benefits of transplant services and specifically states that tissue transplant coverage is limited to allogenic bone marrow only.") NevadaCare relied on the representations of Simkins and her doctors as to the nature of the procedure for which coverage was requested. Based on such representations, it denied coverage for HDC/PSCR under a bone marrow transplant limitation. Such determination was not erroneous, rather, it was the only position rationally supported by the record before NevadaCare. Likewise, NevadaCare's interpretation of the plan terms is not in conflict with the Plan's plain language, as the Plan clearly limits the scope of covered treatments and does not include HDC/PSCR. Simkins never presented to NevadaCare, as alternative grounds for coverage, the argument that HDC/PSCR could be fragmented into allegedly covered treatments, and therefore should not be allowed to argue at this time that failure to consider such fragmentation was an abuse of discretion on behalf of NevadaCare.[7]

Simkins argues that the Plan is ambiguous and such ambiguity should be resolved against the insurer and drafter of the policy, NevadaCare, under doctrine known as *contra preferentem*. Such application of the doctrine has been expressly rejected in *Atwood*, where this Circuit held:

> Atwood argues that, because he interprets the plan to mean that his resignation followed a

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[7] For the reasons stated above, this Court should disregard any such fragmentation argument.

> substantial diminution in his duties or responsibilities and [the administrator] interprets the plan to mean the opposite, the plan must be ambiguous, and hence under contra preferentem, his interpretation should be accepted. **This application of the doctrine would completely do away with the abuse of discretion standard we must apply in reviewing [the administrator's] decision.** 45 F.3d at 1324. (Emphasis added).

Thus, this Court should reject Simkins' contention that the Plan should be interpreted against the drafter.

For the above reasons, this Court should find that no abuse of discretion took place in NevadaCare's decision to deny benefits to Simkins. The judgment of the District Court must be affirmed.

CONCLUSION

The pertinent terms of the Plan are not ambiguous, and NevadaCare did not abuse its discretion in handling of Simkins' claim. Thus, the District Court's grant of summary judgment in favor of NevadaCare should be affirmed. Likewise, District Court's denial of Simkins' motion for summary judgment should be affirmed.

DATED this 1st day of February, 2000.

By: /s/ Constance L. Akridge

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